The Structural Pre-Requisites for Clinical Leadership

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Overview
Following a critical review of the conceptual foundations of current calls for leadership, this paper assesses the extent to which the preconditions for clinical leadership are evident in healthcare settings. In detail, it examines how prevailing professional cultures may be affecting the followership of clinical leaders. It then assess the extent to which existing health policies, structures and methods are aligned to structurally underpin the authority that leaders are meant to exercise.

The flawed characteristics of current calls for leadership
Increasingly, players in health policy circles look to leadership as the bridge between the intention of reform and its effective implementation. Such calls however are conceptually and, hence, practically flawed. Limitations on both these fronts are evidenced by the over-riding concern to identify and then transfer what are presented as the generic attributes of leadership. For example, the NHS Leadership Centre depicts an individual's ability to transform his or her organisation or clinical setting as depending on his/her personal qualities. Among other qualities included here are self-belief, self-awareness, self-management, drive for improvement and personal integrity.[1]

This concentration on traits and style is flawed. Firstly, the approach is based on the now discredited assumption that style and trait are sufficient conditions for leadership and that these traits can be learnt.[2-8] Secondly, the approach denies well-established findings on how social, economic and political factors may influence followership and hence the substance and form of leadership.[9-13]

The continued resort to these assumptions evidences a limited understanding of conceptual differences between authority and power and the way that the presence or absence of authority is expressive of the relationship between leaders and followers. In this context, "A" has power over "B" to the extent that "A" is able to get "B" do something that s/he would not normally do. In contrast, "A"'s authority over "B" depends on the extent to which "B" regards this exercise of power as rightful and legitimate.[14-17] Whereas "A"'s power may be sourced in their greater access (than "B") to scarce resources such as time, money, information etc, the source her/his authority over "B" ultimately lies with "B", that is, in the extent to which "B" regards "A"'s exercise of power as being rightful and legitimate. In other words, leadership authority crucially depends on the existence of a 'following'.

How culture is 'structural' for accomplishing leadership
How this occurs within healthcare settings is graphically demonstrated by findings from a longitudinal and comparative research project in four countries (England, Wales, Australia and New Zealand) involving 3,500 staff in 16 hospitals in 4 countries. Using a validated close-ended questionnaire, the research has mapped how medical, nursing and general managerial staff perceive aspects of the health reform agenda. Included here are their perceptions of :

- interconnections between the clinical and financial dimensions of care;
- initiatives to systematise clinical work;
- the personal power implications of drives to extend multi-disciplinary team-based clinical service provision; and

- the relationship between clinical autonomy and transparent accountability.

As illustrated in Figure 1 below, the findings show marked consistency across countries in differences in the attitudes, values and beliefs of medicine and nursing clinicians, and also medical, nursing and general managers. These differences occur on a number of dimensions: two of which together account for 92.9% of the variation in the data. These were, on the one hand, differences between individualistic and systematised concepts of clinical work and, on the other, differences between clinically divorced and patient centred approaches to reform.

Figure 1. Profiles of professional sub-cultures by country

In overview, each professional group's stance can be described thus:

- ***General managers*** have a strong ascription to both *systematised concepts of clinical work* and to *clinically divorced and externally driven* approaches to reform;
- ***Medical managers*** ascribe to *individualistic concepts of clinical work* with a somewhat variable ascription to *clinically divorced and externally driven* approaches to reform;
- ***Medical clinicians*** ascribe strongly to *individualistic concepts of clinical work* and are equivocal about both *clinically divorced and externally driven* and *patient centred* approaches to reform;
- ***Nurse managers*** have a strong ascription to *systematised concepts of clinical work* and are inclined to a *patient and work practice centred* approach to reform; and
- ***Nurse clinicians*** variably ascribe to *systematised concepts of clinical work* and strongly ascribe to *patient and work practice centred* approaches to reform.

Importantly, as illustrated in Table 1, within England and Wales these differences in the stances of professions are registered in the way that they evaluate different aspects of the program of reform.

Table 1. Professional Stances within England and Wales on Reform Issues

A professional group's stance on a specific issue will affect the extent to which it is disposed to being led towards accepting change on this theme. In general terms, the data show that general managers in England and Wales agreed with all the reform themes. This was also the case for general managers in Australia and New Zealand. In contrast, the evaluative stance of medical and nurse clinicians varied between countries in ways that would affect the leadership capacities of medical and nurse managers to take the lead on implementing policy initiatives regarding improving technical efficiency, clinical accountability and quality.

For example, nurse managers in England and Wales who try to make explicit interconnections between the clinical and resource dimensions of care are likely to find that their efforts are interpreted by nursing clinicians as denying nursing's commitment to the sentient nature of care. Equally, medical managers' strong agreement that clinical decisions are also resource decisions in part reflects the lack of opposition to this proposition among their erstwhile medical colleagues. In contrast, medical mangers' ambivalence on accountability issues and their rejection of work process control methodologies and multidisciplinary teams echo their medical colleagues' stance on these issues.

In summary, the data reflects both the structural position of a medical manager who wants to take the lead on reform and how s/he might respond. For example, on the introduction of work process control, such a medical manager will find themselves questioning their medical colleagues' claimed right to self-define, self-describe and self-validate their work. And the same dissonances are implied firstly, in efforts to extend clinical accountability and secondly, in efforts to underwrite the multi-disciplinary and, hence, team-based nature of service provision. Again, it is likely that what leaders can do about change is limited to what followers regard as 'rightful'. For medical managers, this means that their scope for leadership is much more circumscribed than it is for nurse managers.

If professional cultures set the structural limits of leadership, what influences these cultures?

The foregoing does not mean that the stances of professional groups are fixed and hence that there is no prospect of change. Rather we wish to emphasise the point that the impetus for change will be in what systemically is happening at the level of culture as well as what individual managers within in clinical settings are doing to promote change.

What is involved here is observable in cross-country and cross-time differences within a professional group. Our data suggests that these differences are likely to provide answers to crucial questions such as "What is the impact of health policy at a national level on professional culture?" and "How, and to what degree, do changes in macro policy settings generate change in the attitudes, values and beliefs of specific professional groups?"

The significance of cross-country differences became apparent following a detailed analysis of the stances of nurse clinicians and nurse managers in England and Australia. This revealed marked differences in the way that nurses in each country viewed clinical and resources issues, and their relationships with medicine. It also showed how these differences could be traced to systemic differences between the two countries at two levels: firstly in nurse education (at graduate and under graduate levels) and secondly in the way that professional and industrial bodies within nursing were organised.[18-21]

Similarly, a comparative analysis of the data on medical clinicians and medical managers in Australia and New Zealand showed that the latter were significantly more inclined firstly, to accept interconnections between the clinical and resource

dimensions of care and secondly, to support patient centred public accountability.[22] Explanations for the first of these findings were found, in part, in the more contractually based approaches to service planning, funding and delivery that pertained in New Zealand at the time of the study (1998) and in the greater willingness by New Zealand health policy players to 'own' explicit rationing. The second finding (on accountability) reflects differences in the medico-legal climate of each country resulting from the no-fault provision in New Zealand accident compensation legislation. These provisions mean that the professional indemnity risks faced by New Zealand medical clinicians are substantially less than those of their Australian counterparts.[23-25]

Finally, the significance of policy change within a system became apparent when we examined how the values, attitudes and beliefs of professional groups within the same system change over time. For example, preliminary analysis of longitudinal data on English and Australian medical and nurse clinicians points to significant shifts in how they evaluate efforts to systematise care and how these shifts may be related to systemic changes in policy and in healthcare organisation.[26]

Conclusion.

This paper has illustrated why it is that clinical leadership can be neither assumed nor legislated. We have also shown why engendering leadership within clinical settings is not merely a matter of finding and/or 'creating' people with the right motivation and behavioural attributes. In contrast, we have shown how accomplishing leadership is likely to depend on an interplay between personal, social and structural factors. Its emergence will reflect not merely the presence or absence of people with particular personal qualities but also how contextual factors such as professional subcultures impact on followership. Against this background, we show how the detailed composition of professional cultures can be affected by the policy initiatives of central government. Subsequent papers will show how this alignment between policy, culture and leadership is manifested within clinical settings and what it implies at the level of method, focus and structure for establishing the legal authority of clinician leaders within clinical settings.

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